DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Health
DOH-1002 (Rev.3/91)

APPENDIX 7

# HEALTHCHECK INDIVIDUAL HEALTH HISTORY

| | |
|---|---|
| *Fill out one form for each person screened* | CURRENT MEDICAL ASSISTANCE I.D. NUMBER PER CODE<br>DATE COMPLETED / / |
| NAME OF PATIENT | NAME OF PARENT OR GUARDIAN |
| ADDRESS | ADDRESS |
| PHONE | PHONE |
| BIRTHDATE | SCHOOL AND GRADE OR OCCUPATION |
| PHYSICIAN NAME AND ADDRESS | |
| DENTIST NAME AND ADDRESS | |

## GENERAL HEALTH *(Answer for All Ages)*

| Office Use | Yes | No | Don't Know | |
|---|---|---|---|---|
| 1 | | | | Has it been more than 12 months since this person had a general checkup by a physician? |
| 2 | | | | Has it been more than 12 months since a physician examined this person because of illness or injury? |
| 3 | | | | Has it been more than 12 months since this person had a general checkup by a dentist? |
| 4 | | | | Has it been more than 12 months since a dentist exa mined this person because of pain of injury? |
| 5 | | | | Is there anything about this person's health, growth or development that you are concerned or worried about? If YES, explain. |
| 6 | | | | Does this person always use a seatbelt or carseat in an automobile? |

## DID THIS PERSON EVER HAVE OR DOES THIS PERSON NOW HAVE ANY OF THE FOLLOWING?

| Office Use | Yes | No | Don't Know | | Office Use | Yes | No | Don't Know | |
|---|---|---|---|---|---|---|---|---|---|
| 7 | | | | Unexplained fever | 20 | | | | Vomiting or diarrhea |
| 8 | | | | Poor appetite or feeding problem | 21 | | | | Wheezing or noisy breathing |
| 9 | | | | Loss of weight | 22 | | | | Swollen joints |
| 10 | | | | Loss of consciousness, fainting | 23 | | | | Heart murmur |
| 11 | | | | Head Injury | 24 | | | | Frequent stomach aches |
| 12 | | | | Seizure, convulsions, fits | 25 | | | | Blood in bowel movements |
| 13 | | | | Frequent headaches | 26 | | | | Bladder, kidney, or urinary problems |
| 14 | | | | Eye trouble | 27 | | | | Blood in urine |
| 15 | | | | Earaches, draining ears | 28 | | | | Rashes, eczema, hives, skin problems |
| 16 | | | | Frequent nosebleeds | 29 | | | | Many bruises or bleedings |
| 17 | | | | Chronic cough | 30 | | | | Frequent stumbling, falling |
| 18 | | | | Hearing problems | 31 | | | | Frequent colds or infections |
| 19 | | | | Constipation | | | | | |

## APPENDIX 7
## HEALTHCHECK INDIVIDUAL HEALTH HISTORY FORM
(continued)

| Office Use | Yes | No | Don't Know | HAS THIS PERSON HAD ANY OF THE FOLLOWING? |
|---|---|---|---|---|
| 32 | | | | |
| | | | | Rubella (German measles) |
| | | | | Measles (Red) |
| | | | | Mumps |
| | | | | Rheumatic fever |
| 33 | | | | Did or does this person have allergies? If YES, describe. |
| 34 | | | | Did or does this person have asthma? |
| 35 | | | | Has this person had any serious accidents? If YES, describe. |
| 36 | | | | Has this person had any hospitalizations, operations, major illness? If YES, describe. |
| 37 | | | | Does this person now have any problems which you feel, or which a physician has told you, may be related to any one of the conditions 7 - 36? If YES, describe. |
| 38 | | | | Does this person OFTEN eat things which are not usually considered to be food? (Example: dirt, paint,chips, crayons, clay, starch, newspaper.) If YES, describe. |
| 39 | | | | Does this person have problems with toileting or toilet training? |
| 40 | | | | Does this person get along with family members and playmates? |
| 41 | | | | Does this person have difficulty learning? |
| 42 | | | | Does this person get into trouble in school or dislike school? |
| 43 | | | | Has this person taken prescription medicines in the last 12 months? For what? |
| 44 | | | | Has this person taken non-prescription medicines in the last 12 months? (Example: aspirin, antihistimines, vitamins, food supplements.) What? |
| 45 | | | | Has this person ever had a positive reaction to a tuberculosis test? |
| 46 | | | | Referred for Adolescent Review |
| 47 | | | | ANSWER FOR FEMALES BORN BEFORE 1972: Did the mother of this person take any medications to prevent miscarriage during this pregnancy? |

## IMMUNIZATION HISTORY: Please give the date this person received each of the following:

| Type[Recommended Doses] | None | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 |
|---|---|---|---|---|---|---|
| DTP (Diptheria, tetanus, and whooping cough) [5 doses by school entrance] | | | | | | |
| Td (Tetanus) [every 10 years after school entrance] | | | | | | |
| Polio Oral (by mouth) [4 doses by school entrance] | | | | | | |
| Measles, Mumps, Rubella [2 doses by school entrance] | | | | | | |
| Hemophilus Influenza, type b [at 2, 4, 6 and15 months] | | | | | | |

APPENDIX 7
HEALTHCHECK INDIVIDUAL HEALTH HISTORY FORM
(continued)

# BEHAVIORAL/EMOTIONAL HEALTH

| OFFICE USE | YES | NO | DON'T KNOW | |
|---|---|---|---|---|
| 47 | | | | Does this person have a history of either:<br>● behavioral or emotional problems OR<br>● treatment for behavioral or emotional problems at a<br>● clinic or hospital? If YES for any, explain. |
| 48 | | | | Has anyone in this person's family ever been treated or hospitalized for emotional problems such as: depression, anxiety, mood swings, suicide attempts, or alcohol or drug abuse? If YES for any, explain. |
| 49 | | | | Has this person ever abused alcohol and/or drugs? If YES, explain. |

**50** Has this person ever:

( ) felt hopeless or depressed
( ) had unexplained crying spells
( ) planned or attempted suicide
( ) had peculiar or bizarre thoughts
( ) had trouble eating or sleeping [too much or too little]
( ) had an excess of energy or activity
( ) felt like hurting him/her self
( ) displayed reckless or dangerous behavior
( ) heard things no one else around them heard
( ) show inappropriate emotions [reactions that don't make sense for the situation]

**51** Does this person have any of these problems at school?

( ) poor grades
( ) difficulty in making friends
( ) frequent suspensions from school
( ) fighting or arguing with peers or teachers
( ) frequently lying or stealing
( ) frequent cutting classes or playing hooky

**52** Has this person had any of the following problems at home or in the community?

( ) withdrawing socially [doesn't want to be around other people]
( ) lying or stealing
( ) arguing or fighting with peers or brothers or sisters
( ) clinging excessively to a parent, teacher, or other person
( ) running away from home
( ) problems with police
( ) refusing to follow instructions from parents, or obey the house rules, etc.

Criteria For Referral For Further Assessment:

47. and 49. Refer for a psychiatric assessment if there is a positive response.
48. Refer only if referred criteria are met for any other question.
50. Refer for a psychiatric assessment if any responses are checked.
51. and 52. Refer for a psychiatric assessment if two or more responses are checked.

APPENDIX 7
HEALTHCHECK INDIVIDUAL HEALTH HISTORY FORM
(continued)

## PREGNANCY & DEVELOPMENT

*(Answer for all Ages)*

BIRTH ORDER of this person. Indicate by circling whether this person was the first, second, etc. Do not count still-born brothers or sisters.

| 1st | 2nd | 3rd | 4th | 5th | 6th | 7th | 8th | 9th | 10th or over |
|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MOTHER'S AGE AT THIS BIRTH | Circle one. | Under 17 | 17 - 39 | 40 and over | Unknown | | |
| FATHER'S AGE AT THIS BIRTH | Circle one. | Under 17 | 17 - 39 | 40 and over | Unknown | | |

| 53 | Yes | No | Don't Know | **MOTHER'S PREGNANCY HISTORY** *(Answer only for children UNDER 6 YEARS)* |
|---|---|---|---|---|
| | | | | Was there any bleeding during this pregnancy? |
| | | | | Was the baby born early? If so, how many weeks? |
| | | | | Was there other difficulty or illness during this pregnancy? (Examples: rubella or german measles, high blood pressure, high blood sugar, sexually transmitted disease, etc.) If YES, describe. |
| | | | | Were any X-rays taken during pregnancy? |
| | | | | Were any prescription or other drugs taken during pregnancy? (Examples: tranquilizers, antibiotics, sedatives, medicines for vomiting, medicines - shot or oral - to prevent miscarriage or bleeding.) If YES, describe. |
| | | | | Were any non-prescription medications taken during pregnancy? (Examples: vitamins, iron supplements, frequent aspirin, etc.) If YES, describe. |
| | | | | Was there anything unusual about the labor or delivery? If YES, describe. |
| 54 | | | | **DEVELOPMENTAL MILESTONES** *(Answer only for children UNDER 6 YEARS)* |

Birthweight _____lbs. _____ozs. Length _____inches

*Check the appropriate time this child did each of the following:*

**Follow object with eyes:**
____ Not yet
____ Before one month
____ 1 - 4 months
____ After 4 months

**Roll over:**
____ Not yet
____ Before 2 months
____ 2 - 5 months
____ After 5 months

**Turn to voice:**
____ Not yet
____ Before 3 months
____ 3 - 8 months
____ After 8 months

**Sit alone**
____ Not yet
____ Before 5 months
____ 5 - 9 months
____ After 9 months

**Act shy with strangers**
____ Not yet
____ Before 5 months
____ 5 - 10 months
____ After 10 months

**Walk alone:**
____ Not yet
____ Before 11 months
____ 11 - 15 months
____ After 15 months

**Speak single word:**
____ Not yet
____ Before 9 months
____ 9 - 12 months
____ After 12 months

**Speak simple sentences:**
____ Not yet
____ Before 20 months
____ 20 mo - 2 1/2 years
____ After 2 1/2 years

**Eat finger food alone:**
____ Not yet
____ Before 2 years
____ After 2 years

**Use cup alone:**
____ Not yet
____ Before 2 years
____ After 2 years

Permission is hereby granted for health screening for early detection of health problems for _____
(NAME OF PATIENT)
and for the release of resulting information to appropriate health care providers and health authorities. Permission is also granted to such health care providers and health authorities to release information to personnel conducting this health screening program.

Date ___/___/___ Signature and relationship to patient _____